Disability Insurance Claim Packet

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

Disability Claim Filing Instructions

INSTRUCTIONS – PLEASE READ CAREFULLY AND SUBMIT ALL REQUIRED INFORMATION

We offer four options for filing a disability claim:

1. Call our disability claims team at **1-855-517-6365** (Spanish available). A claims representative is available to assist you between 8 am and 6 pm ET, Monday through Friday. When calling, you should have the following information readily available: Employee's personal information (including social security number), Employer's Name, Group policyholder number, Employee's hire date, contact information for doctors, hospitals or clinics treating the Employee and dates of treatment. You should also have information regarding a worker's compensation or state disability claim if one has been or will be filed.

If you do not wish to call the disability claims team, please complete the following forms and send the forms and supporting documentation to us by:

2. Email to OneAmerica.Claims@customdisability.com;
3. Fax to 1-844-287-9499; or
4. Mail to Custom Disability Solutions, 600 Sable Oaks Drive, Suite 200, South Portland, ME 04106.

If you have any questions when completing the claim forms, please call a claims representative at 1-855-517-6365.

All questions should be answered fully and accurately before a decision on benefit entitlement can be made. All forms should be completed as follows:

Employee's Statement for Disability Insurance Claim form – The Employee should complete this form.

Policyholder Statement for Disability Insurance Claim form – The policyholder (Employer) should complete in full and submit the following information:

- Enrollment forms, requests for increase or decrease in coverage amount, approval of Evidence of Insurability, and/or enrollment information from the policyholder's electronic enrollment system.
- Most recent W2 if salary is based on W2.
- Employee's current job description.

Attending Physician Statement – The primary medical provider treating the Employee for the conditions related to this injury or sickness should complete this form. A list of current medications should be attached to the form. ***(This form is not required for non-complicated Maternity claims.)***

Authorization for Release of Information – The Employee should read, sign and date this form. This form is required for us to obtain additional documentation to support this claim.

Direct Deposit Authorization Agreement – This form should be completed by the Employee if he/she wishes to have disability payments deposited into his/her bank account. Banking information specified on the form should be attached.

Employee's Statement for Disability Insurance Claim Form

Claim is being filed for:

☐ Maternity Claim ☐ Short-term Disability
☐ Long-term Disability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Section I – Employee Information

To avoid processing delay, all questions must be answered fully and accurately.

Employee Name: _____ Employer Name and Policy Number: _____

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Employee Address: _____
City *State* *Zip Code*

Daytime Phone Number: _____ Employee Email Address: _____

Would you like communication via secure email instead of through U.S. Mail? ☐ Yes ☐ No

Are you currently in military service? ☐ Reserves ☐ Active Date active service began: _____

Are you? ☐ Right Handed ☐ Left Handed Gross Annual Salary: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's Gender: ☐ Male ☐ Female Is Spouse employed? ☐ Yes ☐ No

Dependent Children's names and dates of birth: _____

Name of Employer: _____ Employer Phone Number: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Section II – Employment Information

Date you were last physically/Actively at Work: _____

Reason for stopping work: ☐ Sickness/Injury ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ FMLA
☐ Other Leave of Absence ☐ Other Reason: _____

Date returned to work: _____ If part-time, number of hours worked per week: _____

Date of injury or date first noticed symptoms: _____

Your Occupation and Title: _____

You are: ☐ Hourly ☐ Salary ☐ Executive ☐ Management ☐ Salaried/Non-exempt
(Check all that apply) ☐ Bargaining ☐ Non-bargaining

Essential duties of your job at the time of the sickness or injury: _____

How many hours were you regularly working per week with your present employer? _____

Are you authorized to work/reside in the U.S.? ☐ Yes ☐ No

Was your job modified after the onset of symptoms? ☐ Yes ☐ No

If "Yes", what modifications were made? _____

Did/Do you have any other income producing activities or are you self employed? ☐ Yes ☐ No

If "Yes", please describe your activity, job, number of hours worked per week, earnings, and how long you have been working in this capacity: _____

G-28168 6/20/16

Employee's Statement for Disability Insurance Claim Form

Products and financial services provided by American United Life Insurance Company® a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employee Name: _____ Employer Name and Policy Number: _____

Section III – For Maternity Disability Claims Only

If filing for Maternity Disability, complete this section and skip to Section V.

Date of Last Menstrual Period: _____ Expected Date of Delivery: _____

Actual Date of Delivery: _____ ☐ Vaginal ☐ C-Section

Are there any complications experienced with your current pregnancy?: ☐ Yes ☐ No

If Yes, please explain in detail: _____

_____

Have you experienced complications with any past pregnancy?: ☐ Yes ☐ No

If Yes, please explain in detail: _____

_____

Primary Care Physician:	OB/GYN Physician:	Other Provider:
Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
_____	_____	_____
Phone: _____	Phone: _____	Phone: _____
Fax: _____	Fax: _____	Fax: _____

Section IV – Claim Information (Do not complete for Maternity Claims.)

Describe how and where sickness and/or injury occurred or describe the onset and nature of your condition including symptoms. If more space is needed, attach sheet of paper. _____

What events led up to your need to file this claim? _____

_____

Describe your current treatment plan for the sickness and/or injury: _____

_____

Does your return to work or treatment plan include a modified work arrangement? If not, why not? _____

_____

Please list all over the counter and prescribed medications:

Medication	Dosage	Frequency	Prescribed by	Pharmacy

Employee's Statement for Disability Insurance Claim Form

Products and financial services provided by American United Life Insurance Company® a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employee Name: _____ Employer Name and Policy Number: _____

Section IV – Claim Information (continued)

Please list all medical providers:

Medical Provider	Address/Phone Number	Last Appointment

Have you been hospitalized due to this sickness or injury? ☐ Yes ☐ No If "Yes", please provide:

Hospital Name	Address	Dates of Confinement

Section V – Other Income and Benefits

As a result of this disability, are you, your spouse of any of your dependent children receiving amounts from any of the following?

Yes	No	Type	Amount	Date Began	Date Term.	Paid Weekly	Paid Monthly
☐	☐	Vacation/Sick/PTO Pay	$_____	_____	_____	☐	☐
☐	☐	Wages	$_____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$_____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$_____	_____	_____	☐	☐
☐	☐	No Fault Insurance	$_____	_____	_____	☐	☐
☐	☐	Unemployment Compensation Disability	$_____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$_____	_____	_____	☐	☐
☐	☐	Retirement Income (normal, early, or disability)	$_____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$_____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$_____	_____	_____	☐	☐

Have you or will you apply for benefits described above? ☐ Yes ☐ No

Type: _____ Date Application Filed: _____

Type: _____ Date Application Filed: _____

Employee's Statement for Disability Insurance Claim Form

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employee Name: _____ Employer Name and Policy Number: _____

Section VI – Tax Withholding

If benefits are approved, do you want federal income taxes withheld from your payments? ☐ Yes ☐ No

If Yes, complete the following:

I request federal income tax withholding from my sick pay payments. I want the following amount withheld from each payment
$_____ ☐ Weekly (STD) ☐ Monthly (LTD)

The minimum amount we can withhold is $20 per week from weekly payments or $88 per month for monthly payments. Amounts entered must be in whole dollar amounts. (For example, $35 not $34.50) Tax withholding cannot reduce the net amount of each sick pay payment to less than $10.00. This designation will remain in effect until you change or revoke it. You may change or revoke Federal Tax Withholding by providing an updated IRS W-4S form to us. Please refer to IRS form W-4S for additional information. If you elect not to have federal income tax withheld, you remain liable to pay your taxes for the taxable portion of these payments.

Section VII – Signature

The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator Custom Disability Solutions as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Signature of Employee: _____

Name of Employee (please print): _____

Date: _____

G-28168 6/20/16

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

Discretionary Authority

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

The following discretionary authority rights shall apply to all policies except the states below:

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) (or its third party administrator) decides in its discretion the claimant is entitled to them. Except for the functions the policy explicitly reserves to the Participating Unit or Trustee, AUL (or its third party administrator) reserves the right to: 1) manage the policy and administer claims under it; and 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:
1) establish and enforce procedures for administering the policy and claims under it;
2) determine participants' eligibility for coverage and entitlement to benefits;
3) determine what information it reasonably requires to make such decisions; and
4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator, Disability Reinsurance Management Services, Inc. and/or Custom Disability Solutions.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Minnesota
10. Missouri
11. Montana
12. Michigan
13. New Jersey
14. New York
15. Oregon
16. Rhode Island
17. South Dakota
18. Texas
19. Vermont
20. Washington
21. Washington, D.C.
22. Non-ERISA governed policies in New Hampshire and Utah

Policyholder's Statement for Disability Insurance Claim Form

Claim is being filed for:

☐ Maternity Claim ☐ Short-term Disability
☐ Long-term Disability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employer Name: _____ Policyholder Number: _____

Employee Name: _____ Employee Phone Number: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____

Employee Social Security Number: _____ Employee Date of Birth: _____

Employee Hire Date: _____ Number of Hours Worked per Week: _____

Effective Date of Employee Insurance: _____

Did this Employee submit a Statement of Insurability form? ☐ Yes ☐ No

Date Employee was last physically/Actively at Work: _____

Reason for stopping work: ☐ Sickness/Injury ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ FMLA
☐ Other Leave of Absence ☐ Other Reason: _____

Is sickness or injury due to employment? ☐ Yes ☐ No

If "Yes", has Employee filed a Worker's Compensation Claim? ☐ Yes ☐ No

Date returned to work: _____ ☐ Full-Time ☐ Part-Time

If part-time, number of hours worked per week: _____

If Employee has not returned to work, estimated return to work date: _____

Date employment terminated: _____ Date insurance coverage terminated: _____

Employee occupation: _____ Insurance Class/Option: _____

Gross Annual Salary: (Provide salary last reported and approved by AUL in writing.) $ _____

Please indicate how the Employee is paid: (check all that apply)

☐ Hourly ☐ Hourly Rate: _____ ☐ Salaried ☐ Other: _____

☐ Includes commissions (Provide last 12 months of commissions with claim) ☐ Includes bonuses

EMPLOYEE ELIGIBLE FOR:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Vacation/Sick/PTO Pay	$ _____	_____	_____	☐	☐
☐	☐	Wages	$ _____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$ _____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ _____	_____	_____	☐	☐
☐	☐	No Fault Insurance	$ _____	_____	_____	☐	☐
☐	☐	Unemployment Compensation Disability	$ _____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$ _____	_____	_____	☐	☐
☐	☐	Retirement Income (normal, early, or disability)	$ _____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$ _____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$ _____	_____	_____	☐	☐

G-28290 6/13/16

Policyholder's Statement for Disability Insurance Claim Form

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Are premiums paid under a 2004-55 plan? ☐ Yes ☐ No

If "Yes", applies to: ☐ Short-Term Disability ☐ Long-Term Disability

Are the Employee's wages subject to FICA tax? ☐ Yes ☐ No

If "Yes", is Employee subject to: ☐ Full FICA tax ☐ Medicare portion only

Percentage of Employee/Employer contribution to premium for this disability coverage (as of policy year of disability):

Short-Term Disability

Employee ☐ 100% ☐ Other _____ % Is Employee contribution: ☐ Pre-tax deduction

Employer ☐ 100% ☐ Other _____ % ☐ Post-tax deduction

Long-Term Disability

Employee ☐ 100% ☐ Other _____ % Is Employee contribution: ☐ Pre-tax deduction

Employer ☐ 100% ☐ Other _____ % ☐ Post-tax deduction

If 100% Employer paid, do you gross up the Employee's W2 with premium paid on an after tax basis? ☐ Yes ☐ No

If "Yes", applies to: ☐ Short-Term Disability ☐ Long-Term Disability

The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that any insurance coverage or benefits are contingent upon any statements made to AUL, or its third party administrator, Custom Disability Solutions, as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Name of Policyholder (Company)	Print Name & Title of Official Representative
Mailing Address of Policyholder (Company)	Signature
Telephone Number	Fax Number
Email Address	Date

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

Discretionary Authority

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

The following discretionary authority rights shall apply to all policies except the states below:

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) (or its third party administrator) decides in its discretion the claimant is entitled to them. Except for the functions the policy explicitly reserves to the Participating Unit or Trustee, AUL (or its third party administrator) reserves the right to: 1) manage the policy and administer claims under it; and 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:
1) establish and enforce procedures for administering the policy and claims under it;
2) determine participants' eligibility for coverage and entitlement to benefits;
3) determine what information it reasonably requires to make such decisions; and
4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator, Disability Reinsurance Management Services, Inc. and/or Custom Disability Solutions.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Minnesota
10. Missouri
11. Montana
12. Michigan
13. New Jersey
14. New York
15. Oregon
16. Rhode Island
17. South Dakota
18. Texas
19. Vermont
20. Washington
21. Washington, D.C.
22. Non-ERISA governed policies in New Hampshire and Utah

Attending Physician Statement for Disability Claim

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employee Name: _____ Employer Name and Number: _____

Attending Physician's Statement for Disability Claim Form

Please attach copies of all medical records and test results. This form is not required for Maternity STD Claims.

Name of Patient: _____ ☐ Male ☐ Female Date of Birth: _____
First Middle Last

Blood Pressure *(last visit)* Date: _____ ☐ Left-handed

Height: _____ Weight: _____ Systolic: _____ / Diastolic: _____ ☐ Right-handed

1. History

a. Is this condition due to: ☐ Sickness ☐ Injury

b. When did symptoms first appear or injury occur: _____

c. Date patient was unable to work because of impairment: _____

d. Date you first restricted patient's ability to work due to this condition: _____

e. Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", state when and describe: _____

f. Was this patient referred to you? ☐ Yes ☐ No
If "Yes", by whom and what is his/her specialty? _____

g. Have you referred this patient to another treating provider? ☐ Yes ☐ No
If "Yes", to whom and what is his/her specialty? _____

2. Diagnosis

a. Primary diagnosis impacting function: _____ ICD9/10 Code(s) _____
Nature of treatment (including surgery or other procedures):

_____

b. Secondary diagnosis impacting function: _____ ICD9/10 Code(s) _____
Nature of treatment (including surgery or other procedures):

_____

c. Subjective Symptoms: _____

d. Tests Conducted: ☐ X-rays ☐ CT Scan ☐ MRI ☐ EKG ☐ Lab Work ☐ Psychological Testing

e. Objective findings: _____

3. For Pregnancy Disabilities

Are there any present complications or anticipated difficulties in connection with:

Pregnancy ☐ Yes ☐ No Date of last menstrual period: _____

Delivery ☐ Yes ☐ No Expected Date of Delivery: _____

Post Partum ☐ Yes ☐ No Actual Date of Delivery: _____ ☐ Vaginal ☐ C-Section

If yes to any of these, please specify in detail: _____

G-27913 6/16/16

Attending Physician Statement for Disability Claim

Products and financial services provided by American United Life Insurance Company® a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employee Name: _____ Employer Name and Number: _____

4. Dates of Treatment for this condition

a. Date of first visit: _____
b. Date of last visit: _____
c. Next office visit: _____
d. Frequency: ☐ Weekly ☐ Monthly ☐ Other: _____
e. Does treatment regimen include a return to work component if functional improvement is anticipated? ☐ Yes ☐ No

5. Is the patient required to take any prescription medication regularly for the condition? ☐ Yes ☐ No
If "Yes", please provide a listing of all current prescribed medications.

6. Progress

a. Has patient ..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
b. Is patient ..... ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined
If "Hospital Confined", give name and address of location: _____
Dates of Confinement: _____
c. Do you expect any significant improvement in the future? ☐ Yes ☐ No
If "Yes", when?: ☐ 1 Month ☐ 1 - 3 Months ☐ 3 - 6 Months ☐ 6 - 12 Months ☐ Other
If "No", why not? _____

7. Restrictions and Limitations

a. What restrictions, if any, have you placed upon your patient? _____
b. When were these placed and when do you anticipate lifting them? _____

8. Return to work plan

Have you discussed a return to work plan with your patient? ☐ Yes ☐ No
The date you released patient to return to work _____ ☐ Full-time ☐ Reduced hours ☐ Number of hours
Please identify your recommendations for any job modification that would enable the patient to return to work _____
_____

9. Cardiac (if applicable)

a. Functional Capacity (American Heart Assoc. Standards) ☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
b. Was this patient referred to cardiac rehab? ☐ Yes ☐ No

10. Mental / Nervous Impairment (if applicable)

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (No limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (Slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (Moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage interpersonal relations (Marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Slight limitations)

11. Is the patient competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

Attending Physician Statement for Disability Claim

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

OneAmerica®

Employee Name: _____ Employer Name and Number: _____

12.Current Functional Ability

a. In an 8 hour work day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

_____ Hrs.	Sedentary Work Activity	10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.
_____ Hrs.	Light Work Activity	20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.
_____ Hrs.	Medium Work Activity	50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.
_____ Hrs.	Heavy Work Activity	100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

b. Please check appropriate box:

	Occasionally 0% to 33%	Frequently 33% to 66%	Continuously 66% to 100%
Bending	☐	☐	☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push/pull	☐ No. of lbs. _____	☐ No. of lbs. _____	☐ No. of lbs. _____
Lifting (lbs.)	☐ No. of lbs. _____	☐ No. of lbs. _____	☐ No. of lbs. _____

What is this assessment based on? ☐ Observed activity ☐ Measured activity ☐ Physical therapy report

c. Upper Extremity Function – Please indicate upper extremity functional capabilities:

Simple grasp	☐ Left	☐ Right	Comments _____
Pinch	☐ Left	☐ Right	Comments _____
Fine manipulation	☐ Left	☐ Right	Comments _____
Power grip	☐ Left	☐ Right	Comments _____
Repetitive motion	☐ Left	☐ Right	Comments _____

The undersigned Medical Provider represents and warrants any information or documents provided to American United Life Insurance Company® (AUL) by this Medical Provider and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned Medical Provider acknowledges reading and understanding the state specific fraud statements on page 4.

Attending Physician's Signature: _____ Date: _____

Medical Provider's Name (Please Print): _____

Degree / Specialty: _____

Telephone Number: _____ Fax Number: _____ Tax ID#: _____

Office Address: _____
Number/Street

_____
City or Town State Zip Code

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

Group Policy No. _____ Name of Employer _____

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA-COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacy benefit manager, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Custom Disability Solutions (CDS), American United Life Insurance Company® (AUL) and AUL's reinsurer(s) *excluding psychotherapy notes* and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by CDS, AUL, AUL's reinsurer(s) and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, including Disability Reinsurance Management Services, Inc., employed by or representing CDS, AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying CDS in writing of my revocation. However, such revocation is not effective to the extent that CDS and/or AUL have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of or my failure to sign this authorization may impair CDS' and AUL's ability to evaluate my current disability claim and that a lack of required information may be a basis for denying that current disability claim for benefits.

If you reside in **California, Connecticut, Maine, or Massachusetts: This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING CDS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and CDS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: _____ Date of Birth: _____

Claimant Signature (or Authorized Representative): _____ Date: _____

Description of Personal Representative's Authority (if applicable): _____
(*If signed by authorized representative, attach verification of identity.)

Claim ID: _____

Direct Deposit Authorization Agreement

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
OneAmerica.claims@customdisability.com

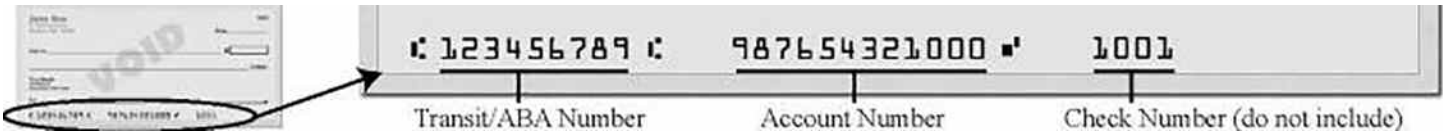
OneAmerica®

☐ New Direct Deposit ☐ Change to Current Direct Deposit ☐ Cancel Direct Deposit

PLEASE PRINT	
Name:	Social Security Number:

Please fill out either the Checking Account Information Section or the Savings Account/Credit Union Information Section. CDS will only deposit to one account.

CHECKING ACCOUNT INFORMATION	
Obtain this information directly from the bottom of your check. Please include a copy of a **voided check**.	
Name of Financial Institution:	
Address of Financial Institution:	
Transit/ABA Number:	Account Number:



SAVINGS ACCOUNT / CREDIT UNION INFORMATION	
Please obtain this information from your financial institution. The information on your deposit slip is **not** applicable for this purpose.	
Name of Financial Institution:	
Address of Financial Institution:	
Transit/ABA Number:	Account Number:

AUTHORIZATION

I authorize the Company to electronically deposit all payments due me from the policy identified above into the account identified above. I discharge and release the Company from further liability for any payments so deposited to my account. I authorize the Company to pursue corrections, if necessary, to any amounts credited to my account in error. The Company will notify me of the error and amount of overpayment.

Any such payments shall be returned to the Company by the Financial Institution if funds are available in my account or shall be returned to the Company by me, my legal representative, my estate or my heirs if the funds in my account are not sufficient to make the required correction.

I understand that the Company may terminate this electronic fund transfer at any time and for any reason and may make payments by check instead. I also understand that I may revoke this authorization at any time by written request which will be effective when received and acknowledged by the Company at its Home Office.

Signature:	Date:

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

In the state of California, the following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

California Insurance Code 790.03

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

(j) Holding oneself out as representing, constituting or otherwise providing services on behalf of the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code without a valid agreement with the California Health Benefit Exchange to engage in those activities.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov or by calling the department's consumer information line at 1-800-927-HELP (4357). You may also obtain a copy of this law and these regulations free of charge from this insurer.

American United Life Insurance Company®
a ONEAMERICA® *company*
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365